No. 88-1503

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In The

Supreme Court of the United States

October Term, 1989

NANCY BETH CRUZAN, by her parents and co-guardians, LESTER L. and JOYCE CRUZAN,

Petitioners,

vs.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, and ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents.

vs.

THAD C. McCANSE, Guardian ad litem,

Respondent.

On Writ Of Certiorari To The Missouri Supreme Court

BRIEF AMICUS CURIAE OF THE EVANGELICAL LUTHERAN CHURCH IN AMERICA IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

DOES THE IMMEDIATE FAMILY OF AN IRREVERSIBLY COMATOSE PERSON HAVE THE RIGHT, FREE FROM UNWARRANTED STATE INTRUSION, TO DETERMINE THE LEVEL OF CARE APPROPRIATE FOR THEIR LOVED ONE?

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INTEREST OF AMICUS CURIAE[1]

The Evangelical Lutheran Church in America ("ELCA") has five and one-third million members in over eleven thousand congregations served by about seventeen thousand pastors. As part of its mission, the ELCA supports twenty-nine colleges, eight theological seminaries, 360 missionaries in 63 countries, 820 chaplains in the armed forces and 300 social service institutions, including hospitals, homes for older persons, and facilities for adults, youth and children with special needs.

The ELCA began its official existence January 1, 1988, as a merger of three predecessor church bodies: The Lutheran Church in America (LCA), The American Lutheran Church (ALC) and The Association of Evangelical Lutheran Churches. These groups trace their history in this country to the seventeenth century.

This is the second brief the ELCA has filed in this Court. The first was filed in support of the Petition for Writ of Certiorari in this case. The filing of both briefs is authorized by the Office of the Bishop and the Commission for Church and Society.

The guiding principles for positions of the Evangelical Lutheran Church in America on issues of social ethics are contained in Social Statements and Task Force Reports of its predecessor church bodies. The ELCA takes the

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[1] The Evangelical Lutheran Church in America has received consent of the parties to the filing of this brief amicus curiae. Consent of Respondents was received from the Attorney General of Missouri and counsel for guardian ad litem, Thad C. McCanse, Esq. The consent of Petitioner was obtained from her attorney, William H. Colby, Esq.

position it does in this brief because of two such documents: a 1977 paper issued by the American Lutheran Church's Task Force on Ethical Issues in Human Medicine [reprinted in Appendix A], and The Lutheran Church in America's Social Statement entitled Death and Dying that was adopted by the Eleventh Biennial Convention of that body in 1982 [reprinted in Appendix B].

Both of these documents recognized that new technologies in medicine can "keep people alive biologically until life becomes an intolerable burden." [App. p. A1] Medical interventions "do not always cure, but sometimes only prolong the dying process." [App. p. B1] With respect to chronically ill persons, the LCA statement took a strong position in favor of treatment except "in case of extreme and overwhelming suffering from which death would be a merciful release, or in cases in which the patient has irretrievably lost consciousness." [App. p. B9]

Similarly, the ALC Task Force paper affirms the use of life support systems whenever they serve "to improve the quality of personal and biological life." [App. p. A4] However, "wherever personality and personhood are permanently lost, artificial supportive measures often are seen as unfair to the dignity of the person. . . ." [App. p. A5]

These conclusions were reached because of the ELCA's theological understanding of life and death, all of which is in God.

God's gift of dominion over the earth calls us "in our lifetime . . . to be good stewards of all that we are and have." [App. p. A6] "Both living and dying are part of the dynamic processes of the created order, which Biblical

faith affirms as being good." [App. p. B2] Both should occur within a caring community that mandates respect for each person. [App. p. B4]

Medical decision-making is a personal matter and "we affirm the human right of individuality which allows us to die our own death within the limits of legal, social, and spiritual factors." [App. p. A3] At the same time, "we acknowledge our interrelated and interdependent nature, and seek to provide an individual facing death with the love and care of family and close friends." [App. p. B5]

Above all, "Christian faith teaches us the duty of preserving health, but does not hold life to be an absolute value . . . Our hope is the hope of the resurrection." As "Christ affirmed his death as an event that glorified God so can we affirm our own death." [App. p. A6] "As life draws to an end, with no hope for health restoration, permitting death is often the most heroic, caring and charitable rendering of stewardship." [App. p. A5]

SUMMARY OF ARGUMENT

The Missouri Supreme Court erred in two important respects in this case. First, it misunderstood the nature of the constitutional right at stake. Second, it failed to recognize that the legitimate interest of the state was already satisfied by the procedure required in the trial court.

The Constitutional right in this case is the type of traditional right that historically has been held to be protected as a fundamental part of liberty in the Fourteenth Amendment. A long line of cases has defined a

private realm of family life beyond the power of the state to regulate. This right of family privacy has received substantive protection and has necessitated procedural guarantees. The historical respect and commitment of our civilization to the sanctity of family authority is consistent with and essential to our traditions of individual liberty. The right of parents or nearest relatives to decide, without unwarranted state intrusion, the level of medical care or the termination of it for an irreversibly comatose loved one fits squarely within the history, purpose and tradition of our constitution. (Pages 6-12)

At times, the right of families to be let alone involves a spiritual dimension. This is especially true in times of grave illness or impending death. In this case, Nancy Cruzan's loving family, following a careful and agonizing deliberation, decided to respect her ideals and beliefs by deciding to discontinue artificial hydration and nutrition. Their decision on her behalf deserves constitutional protection. (Pages 12-15)

The state has the power to protect children and other dependent people, but it may do so only when parental control falters. The trial court made no finding of bad faith by Nancy's parents. The state has a legitimate but limited interest in this case; to assure that family decision-making acted on correct information and from proper motives. Once the state hearing has provided testimony clearly establishing a patient's medical conditions and future treatment options, what remains is a moral decision for the unconscious patient, based as closely as possible on her own view of life and death. The real issue in this case, as the Missouri court does recognize, is not whether proxy decisions will be made, but

who should make them. The choice is among medical personnel who diagnose, state officials who regulate health care, and family who, our constitutional tradition recognizes, can grasp and implement the thoughts, emotions, sensations and spiritual belief of the patient. If state officials are allowed to make these decisions, they necessarily will grant primacy not to the person's life values which they do not know, but to other matters such as efficiency, cost, medical data and their own value judgments. (Pages 15-18)

Although the state has a legitimate interest in protecting the public through the criminal law, it is not triggered here. The historical distinction between merciful omission and deliberate acts continues to be used today to distinguish between homicidal intent, which is not present in this case, and permission for the normal process of death. The state's invasion of family privacy is especially suspect in this case, where its decision effectively condemns Nancy's body to total and continued medical intervention that she does not want. (Pages 18-19).

Protecting the family's right to decide encourages family involvement in and supervision over the treatment of dependent loved ones. The Missouri decision severs family ties by substituting the moral and religious judgment of the state for that of the person. The state's right to regulate should be limited to assuring that family decision-making acted on correct information and from proper motives. All that was accomplished in the trial court in this case. Beyond this Nancy's voice must be heard through her family, whose right to decide should be recognized and upheld. (Pages 20-21)

ARGUMENT

I. FAMILY MEMBERS, MAKING MEDICAL DECISIONS ON BEHALF OF AN INCOMPETENT DAUGHTER ACCORDING TO HER WISHES, HAVE A CONSTITUTIONAL RIGHT TO BE FREE FROM UNWARRANTED STATE INTRUSION INTO THEIR DECISION-MAKING.

This case calls on the Court to define the boundary between the power of state government and the family. Consistent with its prior decisions, this Court should recognize that a family has a constitutional right to make medical decisions on behalf of a comatose loved one. This right is subject only to a state's interest in providing a fair hearing, and in the absence of a showing of abuse, cannot be totally usurped by state decision-makers.

A. The Cruzan's Have A Constitutional Right To Make Medical Decisions On Nancy's Behalf.

The Supreme Court of Missouri appeared to acknowledge a constitutional right in this case, but found that the state's expression of a strong policy favoring life "outweighs any rights invoked on Nancy's behalf to terminate treatment." [Petitioner's App. p. 43] Relying on *Bowers v. Hardwick*, 478 U.S. 186 (1986), the Missouri court expressed "grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient." [Petitioner's App. p. A25]

The Missouri court's reliance on *Bowers* is misplaced and ignores a long-standing group of cases in which this

Court has recognized a constitutional right of privacy in family matters. In *Bowers*, this Court held that the federal right to privacy does not protect homosexual activity, finding "[n]o connection between family, marriage or procreation on the one hand and homosexual activity on the other. . . . " [p. 191]. This Court emphasized in *Bowers*, however, that traditional rights not expressly set out in the text of the constitution are nonetheless protected as fundamental privacy and liberty rights under the liberty provision of the Fourteenth Amendment. Decisions of this Court both before and after *Bowers* firmly establish a range of rights under the rubric of family privacy.

"It is an established part of our constitutional jurisprudence that the term 'liberty' in the Due Process Clause extends beyond freedom from physical restraint." *Michael H. v. Gerald D.*, 109 S.Ct. 2333, 2341 (1989) citing *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) and *Meyer v. Nebraska*, 262 U.S. 390 (1923).

A long line of cases has defined a "private realm of family life which the state cannot enter," *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). These decisions have afforded substantive protection to the decision to marry, *Turner v. Safley*, 107 S.Ct. 2254 (1987), *Zablocki v. Redhail*, 434 U.S. 374 (1978), *Loving v. Virginia*, 388 U.S. 1 (1967); the decision to procreate, *Griswold v. Connecticut*, 381 U.S. 479 (1965), *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J. dissenting), *Skinner v. Oklahoma*, 316 U.S. 535 (1942), the education of children, *Wisconsin v. Yoder*, 406 U.S. 205 (1972), *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923); and family living

arrangements, *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (plurality opinion).

Procedural due process rights have also been deemed essential to protect "[t]he fundamental liberty interest of natural parents in the care, custody and management of their child. . . . " *Santosky v. Kramer*, 455 U.S. 745, 753 (1982). See also *Caban v. Mohammed*, 441 U.S. 380 (1979), *Cleveland Board of Education v. LaFluer*, 414 U.S. 632 (1974), *Stanley v. Illinois*, 405 U.S. 645 (1972), *Armstrong v. Manzo*, 380 U.S. 545 (1965), *May v. Anderson*, 345 U.S. 528 (1953).

These cases reflect the historical respect and commitment of Western Civilization to the "sanctity . . . traditionally accorded to the relationships that develop within the unitary family." *Michael H.*, 109 S.Ct. at 2342. See also *Murphy v. Ramsey*, 114 U.S. 15, 45 (1885). The sanctity of the family is protected by the constitution "precisely because the institution of the family is deeply rooted in this Nation's history and tradition." *Michael H.*, 109 S.Ct. at 2342, citing *Moore*, 431 U.S. at 503. "The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More important, historically it has recognized that natural bonds of affection lead parents to act in the best interests of their children. 1 W. Blackstone, *Commentaries* 447; 2 J. Kent, *Commentaries on American Law* 190." *Parham v. J. R.*, 442 U.S. 584, 602 (1979).

In this case, Missouri's action has totally deprived Nancy's parents of her custody, care and nurture. This result directly contradicts the cases of this court that recognize close family ties and that find a presumption in

favor of family right and duty to be even more important when care and custody of children are concerned, because the parents' claim "is basic in the structure of our society." *H. L. v. Matheson*, 450 U.S. 398, 410 (1981) citing *Ginsberg v. New York*, 390 U.S. 629, 639 (1968). "It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder." *Quilloin v. Walcott*, 434 U.S. 246, 255 (1978) quoting *Prince v. Massachusetts*, 321 U.S. 158, at 166.[2]

Although Nancy Cruzan is a thirty-two year old adult, the primary right of family to custody, care and nurture of children has been recognized in the situation of others incapable of caring for themselves such as "the insane and those who are irreversibly ill with loss of brain function. . . ." *Thompson v. Oklahoma*, 108 S.Ct. 2687, 2693 n. 23 (1988). This presumptive power of family control "includes counseling children in important decisions," *H.L. v. Matheson*, 450 U.S. 398 (1981) and making medical care decisions, *Parham v. J.R.*, 442 U.S. at 603.

B. The Presumption Of Parental Right Is Essential To Our Tradition Of Individual Liberty.

"Properly understood, . . . the tradition of parental authority is not inconsistent with our tradition of individual liberty; rather, the former is one of the basic

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[2] Protecting children has historically included the power of parents to bring actions on their behalf in courts of law and equity. See *Blackstone, supra*; J. Story, *Equity Jurisprudence*, Sec. 1742-84 (1886).

presuppositions of the latter." *Bellotti v. Baird*, 443 U.S. 622, 638 (Powell, J. concurring). "The child is not the mere creature of the State. . . . " *Pierce*, 268 U.S. at 535.

Affirming the right asserted here by the family of Nancy Cruzan involves no more than a logical extension of prior cases regarding family privacy. *Meyer v. Nebraska*, 262 U.S. 390 (1923); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). In those decisions, the Court recognized that this right has no explicit basis in the language of the constitution nor in prior decisions of this Court. Nor did either involve an assertion of a failure of procedural due process. But, as Justice Harlan so cogently insisted in his dissenting opinion in *Poe v. Ullman*, 367 U.S. 497 (1961), the due process clause of the Fourteenth Amendment must reach beyond procedural regularity or else the State could, "with the fairest possible procedure . . . destroy the enjoyment of [life, liberty and property]" *id.* at 541, with no constitutional redress.

The right asserted here, as well as that in the *Poe* case, are rights " 'which are . . . *fundamental*; which belong . . . to the citizens of all free governments.' " *id.* quoting *Corfield v. Coryell*, 4 Wash. CC 371, 380, 6 F Cas 546 (1823). Although Justice Harlan was concerned in *Poe* about finding and defining what appeared to be a novel claim to constitutional protection, he was certain of the need to do so. In articulating his decision-making process, he found no formula for due process, but recognized the need to consider the balance our nation historically and traditionally has struck between "the liberty of the individual and the demands of an organized society." 367 U.S. at 542. Arguing that judges should guard against "unguided speculation" by careful attention to what history teaches are our living traditions, he recognized that

the concept of liberty is not a series of "isolated points" of rights explicitly enumerated in the Bill of Rights, but rather a "rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints." *Id.* at 543. These fundamental rights must be found in "the purposes of [the enumerated rights] and not [in] their text," *id.* at 544, as well as in the history and tradition which sheds light on that text. "Due process," therefore, and "liberty," which vaguely define the outer limits of state power, reach beyond those rights explicitly spelled out in the constitution.

The history, purpose and tradition of the constitution similarly confirm the existence of a right of parents or nearest relatives to determine, without unwarranted state intrusion, the level of medical care or the termination of it for their irreversibly comatose loved one. The inalienable personal rights, tellingly relied on in the Declaration of Independence, served as the understood background of the Bill of Rights. The whole purpose of the Ninth Amendment was to respond to the well-founded fears of some of the founding fathers that any enumeration of fundamental rights must be incomplete. James Madison, in drafting the Ninth Amendment, clearly sought to avoid the negative implication of the enumerated list of rights, that rights not enumerated did not exist.[3]

It would be ironic if a society which enumerated the limits of the federal government's power to intrude into

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[3] See, Barnett, *Reconceiving the Ninth Amendment*, 74 Cornell L. Rev. 1 (1988); Massey, *Federalism and Fundamental Rights: The Ninth Amendment*, 38 Hastings L. J. 305 (1987); Sherry, *The Founder's Unwritten Constitution*, 54 U. Chi. L. Rev. 1127 (1987).

the home by quartering troops or by using warrantless searches, would not also have limited the power of the government to interfere with decisions affecting one of the most sacred of family events, the death of a loved one, if such an intrusion had then been medically feasible.

Parental and family privacy is essential to our culture, traditions and history because the family cultivates and transmits shared ideals and beliefs, fosters diversity, acts as a critical buffer between the individual and the power of the state and safeguards the emotional attachment of close ties that enable persons to define [their] identity. *Roberts v. United States Jaycees*, 468 U.S. 609, 619 (1984). All of these purposes are "central to any concept of liberty." *Id.* As Mr. Justice Brandeis explained in *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (dissenting opinion): "The makers of our Constitution . . . recognized the significance of man's spiritual nature, of his feelings and of his intellect. . . . They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone – the most comprehensive of rights and the right most valued by civilized men."

C. For Many, Especially When Facing Death, The Roots Of Family Privacy Lie In Spiritual Beliefs.

The right of families to be let alone often involves a spiritual dimension. At times, religious belief motivates private action that directly conflicts with the power of the

state. *Wisconsin v. Yoder*, 406 U.S. 205 (1972), *West Virginia Board of Education v. Barnette*, 319 U.S. 624 (1943). Other cases also involve claims of Fourteenth Amendment protection against the power of the state where religious belief primarily motivated the private action. *Meyer v. Nebraska*, 262 U.S. 390 (1923) and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925). Ultimate questions of life and death compel everyone to confront his or her religious beliefs or fundamental value systems.

For many, if not most, the significance of our spiritual nature takes priority in times of grave illness or impending death. For persons of faith, decisions concerning care for a loved one will inescapably involve religious belief. Not many years ago, most deaths occurred at home. There, "surrounded by family and friends, dying people were invited to repent of their sins, bless the children present, ask forgiveness, bid farewell and make recommendations." [App. p. A1] Death occurred as a natural and private experience. Today, "people often experience death in the sterile environment of hospital or nursing home," [App. p. A2] often connected to a "new technologies (that) do not always cure but sometimes only prolong the dying process, at times with great suffering" (App. p. B1)

In considering this case, the ELCA respectfully requests this Court to consider that a person of faith who makes a decision to discontinue artificial hydration or nutrition should not be forbidden from doing so. We believe that for us, such a decision requires prayerful consideration of the gift of life from God, respect for the

unconscious person's preferences and hope in the resurrection over death. Continued life, ordered by state officials over family objection, should not be allowed to frustrate religious belief that accepts death as part of the created order [App. p. B3] and proclaims ultimate victory over death through the promise of the resurrection of the body [App. p. B4]. Our freedom to believe and to act on this belief in the privacy of our families is inextricably bound to the Cruzan family's struggle to do the same.

In contemplating death, humans share their greatest intimacies and most profound beliefs. To many, these beliefs include the comfort of a loving God who creates us and our world and who entrusts life, nurture and growth to our guardianship. Part of this creation includes the abundant blessings of medicine, which offers us freedom to live longer and fuller lives than ever before in human history. Our use of medical intervention, like our use of the earth, must be for the service of humankind. Though we as Christians fight for life and treasure it, when life is severely burdened by continual medical intervention and when life in community is no longer possible, we trust in the assurance of a new life.

In this case, Nancy Cruzan's loving family, following a careful and agonizing deliberation, has respected Nancy's ideals and beliefs by deciding on her behalf to discontinue artificial hydration and nutrition. Their decision was based on a lifetime of knowing Nancy and what she would want, on her prior expressed wishes and on careful family deliberation and prayer. The family's decision was affirmed by an extensive trial proceeding, and concurred in by a guardian ad litem appointed to protect

Nancy's interests. That decision, lovingly made and carefully considered, deserves constitutional protection.

II. THE MISSOURI DECISION, WHICH SUBSTITUTES THE MORAL AND RELIGIOUS JUDGMENT OF THE STATE FOR THAT OF THE CRUZAN FAMILY, FAILS TO LIMIT THE LEGITIMATE STATE INTEREST IN THIS CASE TO ASSURING A CAREFUL DELIBERATION AND FAIR DECISION ON BEHALF OF AN INCOMPETENT PERSON.

Government regulation of the family is appropriate only where forbidden conduct substantially threatens the public safety, peace or order, see e.g. *Reynolds v. United States*, 98 U.S. 145 (1879); *Jacobsen v. Massachusetts*, 197 U.S. 11 (1905); *Prince v. Massachusetts*, 321 U.S. 158; and where the state regulation is "appropriately designed to reach such evils." *Id.* at 169.

The well-being of children and other dependent people "is of course a subject within the State's constitutional power to regulate . . . ." *Ginsberg v. New York*, 390 U.S. at 639. The State of Missouri, however, goes far beyond appropriate regulation in this case because it totally usurps parental control when no showing has been made that Nancy's parents sought to act on incorrect information or improper motivation. If a conflict is asserted by individuals, this fact might "require intervention of the State to determine where the rights of one end and those of another begin." *West Virginia Board of Education v. Barnette*, 319 U.S. 624, 630 (1943). But only "if parental control falters" *Schall v. Martin*, 467 U.S. 253, 265 (1984) should the state "play its part as parens patriae." *Id.*

In this case, as in *Parham v. J.R.*, 442 U.S. at 603, there was "no finding by the [trial] court of even a single instance of bad faith" by Nancy's parents. The entire testimony in the Missouri probate court indicated that her parents were promoting Nancy's will and seeking to implement her wishes. Testimony of other family members and friends confirmed this, and a separately appointed guardian ad litem concurred as well.

A. The State's Legitimate Interest Is Limited To Providing A Fair Hearing.

The state, of course, has a legitimate interest here, but a strictly limited one. The state should assure that the family acted on correct information and proper motives. The state's purpose, therefore, was to assure that decisions about Nancy's care were based on accurate medical facts and were consistent with her true beliefs. Once it was clear that these goals were met, however, the state's power to limit parental authority ceased. "The statist notion that governmental power should supersede parental authority in *all* cases because *some* parents abuse and neglect children is repugnant to American tradition." *Parham v. J.R.*, 442 U.S. at 603. The state may require a hearing to assure that abuse and neglect do not exist, but may not terminate parental authority over the child absent such a finding. *Santosky*, 455 U.S. 745.

The real question confronting this Court is not whether third party decisions should be made, but who should make them. The Missouri court understood that someone must make medical decisions on an individual basis for dependent and incompetent persons when it

insisted that "[t]he issue . . . is whether feeding and providing liquid to Nancy is a burden *to her*." (Petitioner's App. pp. 36-37) Stated this way, the proper approach should emphasize the expertise of each group in arriving at the best, albeit imperfect, decision, for each individual patient.

In this case, the state's hearing facilitated clear and convincing medical testimony which established " . . . that Nancy will never interact meaningfully with her environment again" and that "[s]he will remain in a persistent vegetative state until her death, . . . totally dependent on others for her care." [Petitioner's App. p. 34] The state's hearing also provided the occasion for those who knew Nancy and her wishes to testify, and for a court appointed guardian ad litem to independently investigate and weigh the medical and personal facts of the case.

Once the medical evidence clearly established her condition and future treatment options, medicine had offered what it could. Once the state hearing produced testimony from friends and relatives and discovered no wrongful motives, the state had facilitated all it could. What remained was a moral decision based on these facts that would most closely uphold Nancy's own view of her life and death. The Missouri court assumes that the state is the moral repository of individual belief concerning life and death. Our constitutional jurisprudence recognizes that this right was never given to the state and, absent abuse by another, is beyond the power of the state to regulate.

If the state is allowed to reverse decisions on behalf of incompetent patients made by families on the basis of their often intimate knowledge and honest endeavor to care for a relative as she would want, then these decisions will be made by unrelated state officials on the basis of their own morality. Lacking the benefit of information concerning a particular person, they will necessarily consider what they do know: cost, efficiency, medical data, and their own view of certain classes of cases or disorders.

The state's parens patriae power is especially offensive when it coerces standardized behavior. Thus in *Meyer v. Nebraska*, 262 U.S. 390, *Pierce v. Society of Sisters*, 268 U.S. 510, and *Wisconsin v. Yoder*, 406 U.S. 205, the state's power to require education was unquestioned, but the "means adopted . . . exceed[ed] the limitations upon the power of the state" *Meyer* at 402. Though the state can mandate instruction, its police power "excludes any general power . . . to standardize its children by forcing them to accept instruction from public teachers only." *Pierce* at 535. Families and individuals such as the Cruzans similarly have a fundamental right to be free from forced existence where disease or injury has so compromised biological function that all hope of recovery is gone and human interaction is totally impossible.

B. Homicide And Suicide Are Not At Issue In This Case.

Another legitimate state interest lies in protecting the public order through the criminal law. Families and individuals have no fundamental right to die at whim. That

certainly is not the case here. The Cruzans' decision cannot be viewed as homicide or aiding a suicide. Historically, suicide occurred only if a direct and deliberate act ended life. Blackstone, *Commentaries Book IV:189* (9th ed 1783). Homicide or aiding a suicide was also limited to a deliberate affirmative act. See e.g. *Regina v. Wagstaffe*, 10 Cox Crim. L. Cases 530, 533 (1868). This distinction between deliberate acts and merciful omissions continues today and has been applied to situations where life supports originally undertaken for a restorative purpose no longer provide hope. See e.g. *Barber v. Superior Court*, 147 Cal. App. 3d 1006 (1983). The ELCA similarly believes that a "deliberate act is far removed from decisions which allow people to die. . . . Permission for the normal process of death is an act of omission in the spirit of kindness and love . . . . [App. p. A6]

Under the guise of the state's power to protect life, the Supreme Court of Missouri has in fact condemned Nancy's body to continued physical invasion necessitated by medical intervention that renders her totally dependent on impersonal machinery for even the vegetative acts of existence. The state's invasion of family privacy is especially suspect in a case such as this, where "the Government's purposes are beneficent . . . . The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding," *Olmstead v. U.S.*, 277 at 479. Undertaken originally for a restorative purpose, medical intervention must, in Missouri's view, be continued forever, irrespective of the lack of success or benefit, physical or moral, to the patient or the family. The state of Missouri now controls and mandates the continuation of Nancy Cruzan's every function.

C. Encouraging Rather Than Preventing Family Involvement In Decision-Making Will Best Guard Against Abuse Of Dependent People.

Perhaps the Missouri Supreme Court's chief concern in this case was preventing abuse of dependent people. If so, it should care about encouraging the involvement of as many individuals in the care of each other as it can. Instead, its decision requiring state power to supersede family choice acts to sever family ties at the time dependence on institutional care begins. At the point of institutional involvement, the family loses control to the institution's policies, regulated or determined by the state. Out of sight and out of control, the care of dependent people becomes monitored by no one but the bureaucratic regulators themselves.

Loss of control to impersonal institutions has another less obvious but equally troublesome result. Family members who seek to maintain control may initially refuse to consent to treatment, fearing the consequences of their later inability to withdraw consent should treatment become hopeless and burdensome. Those who hope that such a situation will not occur, such as the Cruzans, are left to face the agonizing prolongation of a loved one's suffering. In addition to this, they must fight guilt heaped on them by a powerful state that tells them their compassionate decision is morally wrong.

The Missouri court in this case, therefore, should be free to fashion a rule that establishes a commitment to life as long as hope for recovery remains. It should also be free to impose procedural due process requirements that assure that medical diagnosis and prognosis are carefully

evaluated.[4] It may even require an unrelated guardian ad litem who will independently investigate the situation. All of this was accomplished in the trial court in this case. What the Missouri Court should not be free to do is to order continued intrusion into Nancy's body to maintain biological existence for a person who insists in the only way she is able, through her closest family, that she has had enough. Nancy's doctors agree that she will not improve; her parents, the repository of her prior existence, simply ask to let her depart in peace.

When we as Christians have lived our life and our earthly bodies fail, we wish our families to be free on our behalf to repeat the words of Simeon, upon seeking the infant Jesus: "Lord, now lettest thou thy servant depart in peace according to thy word; for mine eyes have seen thy salvation which thou hast prepared in the presence of all peoples." *Luke* 2:29-31

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[4] Due Process may include a guardianship procedure or more informal ethics committee consult in a local institution. See e.g. *In re Quinlan*, 70 N.J. 10, 49, (1976) *cert. denied*, 429 U.S. 922 (1976); Institutional Ethics Committees and Health Care Decision Making (R. Cranford & A. Doudera eds. 1984); Whiteneck & Brown, Forum Allows LTC Facilities to Face Ethical Issues Together, 69 Health Progress 82 (1988), Brown, Miles & Aroskar, The Prevalence and Design of Ethics Committees in Nursing Homes, 35 J. Am. Geriatrics Soc'y 1028 (1987).

CONCLUSION

For the reasons set forth herein, your amicus curiae requests that the judgment of the Supreme Court of Missouri be reversed and that of the trial court be reinstated.

Respectfully submitted,

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APPENDIX A

DEATH AND DYING

An analysis offered by Task Force on Ethical Issues in Human Medicine, Office of Research and Analysis, The American Lutheran Church – July 1977.

A. Facing Death

1. Death is a natural event in the course of human life. However, we experience a paradox about death. We have the technological means to make dying easier, yet we may have arrived at a time in life when we have overlooked the meaning of persons. Our society has the technology to keep people alive biologically until life becomes an intolerable burden. Therefore, moral problems exist with respect to death and dying in a technological society.

2. Earlier societies respected death through ritual and customs that gave meaning to the personal aspects of death. Most often death occurred at home. Surrounded by family and friends, dying people were invited to repent of their sins, to bless the children present, ask forgiveness, bid farewell, and make recommendations. Death occurred as a natural experience, expected and understood. Yet death, then as now, remains the most stressful of all human events.

3. Death seems to have lost its public, social, and spiritual character in a new style of dying. What has become important is that one dies in a manner that can be accepted and tolerated by a surviving family, friends, medical personnel, and the church. Today people often

experience death in the sterile environment of hospital or nursing home. One may die alone, surrounded by people who often abandon the dying person for multiple reasons. Often the dying person plays the role of the one who does not know, or want to know, that death is imminent. "Shielded," isolated, and sedated, the dying person experiences death as a tragic comedy, supported by a cast of actors and actresses playing deceptive roles in a conspiracy of silence.

B. Affirming Life – and Death

4. We believe in the sanctity of life. This means that life is to be celebrated in the spirit of creative Christian living since life has worth, meaning, and purpose both in its living and in its dying. Christ's work of redeeming and transforming people begins in baptism, yet it is directly related to death. For baptism points in two ways – to creation and to eternity. The one who is baptized dies with Christ and is raised with him. Baptism binds together the believer and Christ within one body, the church. Our baptism is into the death and resurrection of Jesus and is our own journey through death to life, death of the sinful self and the birth of the new self with all that it implies for the meaning of human life. In the Lord's Supper we experience repeatedly the real presence of Christ in a reaffirmation of life, dignity, forgiveness, and promise. Faith in Christ affirms the fact that his death and resurrection are meant for all persons on this earth.

5. We affirm that death is a personal matter. Strong ambivalent feelings toward death make for our difficulty in communicating with each other about this event. We

are both fearful and yet curious about death. Our own personal feelings, personality, hopes, and experience of faith are major factors in our personal fear and denial of our acceptance of death. Coping with our own death and the death of others is further colored by society's attitude toward life. Contemporary society, with its emphasis on youth, affluence, and technology is preoccupied with fun morality. This confuses the wisdom of the ages, affecting values of life as well as of death.

6. We affirm the human right of individuality which allows us to die our own death within the limits of legal, social, and spiritual factors. Death is a personal experience. Our relationship with the dying is a relationship with a person. Persons have the right to die peacefully – respected, cared for, loved, and inspired with hope. Those who care for the dying, namely family, physicians, nurses, and the clergy, merit our high regard for this serious task.

C. Defining Death

7. We seem to need a definition as to when death occurs. Medical and technological advances in supportive therapy and resuscitation measures have given hope to many, but also clouded the issue of when death occurs. No exact biological, legal, or theological determinants are clear. Medical and legal bodies have been seeking new guidelines for consideration on this issue. One resolution calls for a legal definition of death as the "irreversible, total cessation of brain function." Another definition discusses the irreversible cessation of the functioning of all vital organ systems.

8. We affirm that definitions of death consist of more than biological facts. They must also consider the personal and the spiritual dimensions of life. Since the dimensions of biology and personhood are present in every instance of life and death, both deserve equal consideration in any serious attempt to render definition.

D. Sustaining Life

9. When death is judged to be certain and imminent, we affirm that grave injustice to the respect and memory of persons is rendered if extraordinary technology is applied. Our highest concern is for the total person rather than technological curiosity and mechanical performance. We are confronted with values of human and personal life in the face of every death.

10. Wherever life support systems can be used to improve the quality of personal and biological life, we heartily affirm their use. We respect medical advances as marvelous instruments for serving others. Social justice, charity, potential health, and the respect of personhood usually determine the reasons for continuing artificial support systems. We affirm the person's right in these situations to reasonable health care for maintaining and sustaining personal life, if one so chooses. When people consciously will life, experiencing existence with meaning and purpose, suffering is not in vain. Hope, comfort, and love should be shared with those suffering.

11. Christianity has long taught that suffering can have meaning. Through it God can work his grace for the one who suffers and for others. Redemptive suffering is meaningful pain. This is markedly different from the

dehumanizing and mindless suffering of the artifically-maintained terminally ill.

E. Allowing Death

12. We affirm that in many instances heroic and extraordinary means used to prolong suffering of both the dying person and the loved ones is unkind. Wherever personality and personhood are permanently lost, artificial supportive measures often are seen as unfair to the dignity of the person and an extreme cost that is burdensome to the family. Families in these cases need not feel a burden of guilt for refusal to try unusual, heroic, and extraordinary life support. Where physicians have determined the irreversible phase of a terminal illness, we affirm that the person, young or old, has a right to a peaceful death. As life draws to an end, with no hope for health restoration, permitting death is often the most heroic, caring, and charitable rendering of stewardship.

13. We affirm that every situation, in the context of dying persons, deserves consideration and decision on its own merit. We affirm that life is to be respected. Respect for the patient requires acceptance by others of that person's desires for life and death. Wise counsel by physicians, the clergy, and members of the health care team should be made available to every family and person facing the crisis of death. Wherever possible, the dying person has a right to be informed of the nature of the illness and the likelihood of imminent death. One should be so informed in love.

14. We affirm that direct intervention to aid the irremediably deteriorating and hopelessly ill person to a

swifter death is wrong. While direct intervention in many cases may appear "humane," deliberate injection of drugs or other means of terminating life are acts of intentional homicide. This deliberate act is far removed from decisions which allow people to die – like shutting off a life-supporting machine or even withholding medication. Permission for the normal process of death is an act of omission in the spirit of kindness and love within limits of Christian charity and legal concerns. Direct intervention to cause death, known as direct euthanasia, can not be permitted. We affirm there is a distinct moral difference between killing and allowing to die.

F. Living under the Gospel

15. Christian faith teaches us the duty of preserving health, but it does not hold life to be the absolute value. While we are often helpless to contend with death, we are not helpless in the acceptance of death. We should accept it with all of its devastation to our earthly hopes and values and, in doing, affirm the ultimate victory we gain in Christ. Our hope is the hope of the resurrection. As Christ affirmed his own death, so can we our death. As he affirmed his death as an event that glorified God, so can we affirm our death. Christ's victory over death makes our death the climax of life, and end to which we have been continually moving.

16. Christians live under the Gospel. In our lifetime, we are called to be good stewards of all that we are and have. Stewardship of life, even our death, is filled with critical moments of tension, joy, and anguish. We affirm the fact of our faith that death, too, has meaning, as life

has meaning. We affirm that to the Christian, dying can be the summit from which one can view the totality of one's life, an accounting of personal stewardship. In grace, we can boldly claim the promises of God about life and death. The promises are everlasting.

APPENDIX B

SOCIAL STATEMENTS

THE LUTHERAN CHURCH IN AMERICA

DEATH AND DYING

Adopted by the Eleventh Biennial Convention,
Louisville, Kentucky
September 3-10, 1982

Today it is commonplace to speak of the triumphs of modern medicine – achievements such as open heart surgery and organ transplants, dialysis machines that substitute for the kidneys, pacemakers that regulate the beating of the heart, and vaccines that have made once-dreaded diseases almost forgotten words. Each of these discoveries has saved countless lives and relieved much suffering. None of this, however, has changed the fact that death still occurs. The new technologies do not always cure but sometimes only prolong the dying process, at times with great suffering. The irony of modern medicine is that with the new technologies that vastly expand the range of what it is possible to do has also come the anguish of deciding when it is appropriate to use these capabilities.

Nowhere are these ethical dilemmas more pressing than with respect to death and dying. A terminal cancer patient who is experiencing great pain suffers cardiac arrest; should the patient be resuscitated? A newborn infant with massive and multiple birth defects is unlikely to survive without surgical intervention; is such intervention appropriate? A family member with a life-threatening illness refuses to undergo treatment; should

treatment be administered in violation of his or her expressed wishes? In these and countless similar situations, we confront not only the grief and anguish always associated with death and dying, but also new and difficult moral decisions that call for prayerful reflection and the support of a caring community.

THEOLOGICAL PERSPECTIVES ON DEATH AND DYING

Perspectives on death and dying within the Christian tradition, both in its biblical origins and in its subsequent development, reflect several contrasting and complementary themes:

Death as Natural. Death is frequently viewed as a natural part of the life cycle. Like all other creatures, human beings have a limited life span. "The years of our life," the psalmist observed, "are threescore and ten, or even by reason of strength fourscore" (Psalm 90:10) The fact that our span of life is limited serves to remind us that we are finite. We are created by God; we are not God. Both living and dying are part of the dynamic processes of the created order, which biblical faith affirms as being good. The story of Abraham's death reflects this view: "Abraham breathed his last and died in a good old age, an old man and full of years, and was gathered to his people" (Genesis 25:8).

Death as Tragic: Death may also be experienced as an unwelcome event that involves a tragic dimension. Sometimes this is because death seems untimely, as in the case of a dying child, a youth, or an adult in the prime of life. Or its unwelcomeness may be due simply to the desire to

continue living rather than depart life, a desire that in its own way gives eloquent testimony to the goodness of the life that God has created. Sometimes the reluctance to die arises from dread of the suffering which may accompany the dying process. Thus it is in keeping with a wide range of human experience that the psalmist prays for deliverance form mortal illness: "Turn, O Lord, save my life; deliver me for the sake of they steadfast love" (Psalm 6:4).

Death as Friend. When dying involves prolonged suffering, death can be experienced as a deliverance, and in this sense as a friend. This does not imply that one should deliberately end life to avoid suffering, for the Christian witness is that meaning and hope are possible even in deepest adversity. It does imply that death, when it brings relief from suffering, can be understood and accepted as merciful.

Death as Enemy. Even though death must be viewed as part of the created order and can sometimes be a friend, the sinfulness of the human condition makes death an enemy. As the apostle Paul puts it, "The sting of death is sin" (I Corinthians 15:56). The alienation and estrangement that are pervasive in our lives make us unready to face death, an anxiety that may be heightened by fear of what lies beyond the grave.

Victory over Death. The New Testament message of Christ's victory over death speaks directly to this alienation and anxiety. Through Baptism, the believer is buried with him "into death, so that as Christ was raised from the dead by the glory of the Father, we too might walk in newness of life" (Romans 6:4). The new life of faith

enables the Christian to face death with courage and with the assurance of forgiveness. The promise of the resurrection of the body and eternal life provides comfort and reassurance that death is not the end.

Whether death is viewed as natural or as tragic, as a friend or as an enemy, all who experience death-and-dying situations can be certain of God's love. Thus the apostle Paul asserts, "For I am sure that neither death, nor life, nor angels, nor principalities, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord" (Romans 8:38-39).

ETHICAL DECISION-MAKING

Careful and prayerful reflection in the immediacy of the situation is an essential ingredient in a responsible decision-making process. At the same time, Scripture, tradition, and the shared wisdom of Christian people provide important resources for making these decisions.

While the exact nature of death-and-dying situations can never be anticipated fully, it is possible to identify interpretive principles that are useful in shaping our response. These include the following:

1. Life is a gift of God, to be received with thanksgiving.
2. The integrity of the life processes which God has created should be respected; both birth and death are part of these life processes.
3. Both living and dying should occur within a caring community.

4. A Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions.
5. Truthfulness and faithfulness in our relations with others are essential to the texture of human life.
6. Hope and meaning in life are possible even in times of suffering and adversity – a truth powerfully proclaimed in the resurrection faith of the church.

The decision-making process involves not only the question of what principles should be used in responding to death-and-dying situations but also the questions of who should make such decisions. If the person is capable of actively participating in the decision-making process, respect for that person mandates that he or she be recognized as the prime decision-maker. At the same time, to relegate such decisions solely to the individual facing death is to deprive that person of love and care. Therefore, it is appropriate that the physician, family members, close friends, the pastor, and other members of the health care team play a supportive role.

If the person in question is not capable of active participation, the situation is somewhat more complex. In some cases, the person's clearly stated preferences, made before he or she lost the capacity to participate, are on record; respect for that person requires that these preferences be given recognition. In other cases, no preferences are on record because the person never gave expression the his or her preferences while still able to do so, and is now too weakened to respond. If the situation involves a child under the age of majority, who is therefore legally

incompetent, or a person who is mentally impaired and hence unable to participate fully in the decision-making process, a shared decision-making process is preferable. Collective wisdom is likely to result in better decisions, and no one should be left to bear alone the full burden of deciding. Participants in this decision-making process may include family members, the physician and other health care professionals, the pastor, and others close to the person. If it is not possible for those immediately involved to reach a consensus, a hospital ethics committee, if one exists, can be an important resource. Appeal to the courts should be avoided unless so doing is the only way to protect individual rights or to resolve the controversy.

WITHDRAWING AND WITHHOLDING TREATMENT

Among the most difficult decisions which confront family members and others in death-and-dying situations are those that involve withdrawing or withholding medical treatment. Opinions differ as to whether there is a significant ethical difference between withdrawing a treatment (e.g., a respirator) that has already been initiated, and simply deciding not to administer it in the first place. Both, essentially, are decisions not to treat.

The situations in which these treatment decisions arise vary widely. At least three different types of situations can be identified, each of which demands a different response:

A. The Irreversibly Dying Person

The first type of situation involves persons whose disease is progressive and for whom no effective therapy is available. As the final stages of the dying process occur, there comes a time to recognize the reality of what is happening by refraining from attempts to resuscitate the person and by discontinuing the use of artificial life support systems. To try desperately to maintain the vital signs of an irreversibly dying person for whom death is imminent is inconsistent with a Christian ethic that mandates respect for dying, as well as for living.

This does not, however, in any way preclude supportive care intended to maintain comfort and otherwise respond to the needs of the dying person. Indeed, quite the opposite is the case; when no cure is available, the responsibility to extend loving care not only continues but assumes even greater importance. This includes not only controlling physical pain, but also responding to the fear, guilt, and anger, the sense of isolation, the blocked communications, and the family stress that are often experienced by the dying.

B. Burdensome Treatments

In some cases there are forms of therapy which offer prospects for sustaining life but which themselves involve considerable discomfort, thereby necessitating a choice between quantity of life and quality of life for the patient. Examples of this type of situation include persons with widespread malignancy who are experiencing extensive side effects from chemotherapy and terminally ill children whose lives can be sustained for a greater

period of time if they are hospitalized, but who will be separated from their familiar home environment. In such cases, the issue is whether it is preferable to have a greater number of days that are overshadowed by the rigors of therapy or a lesser number of days that are more peaceful, i.e., whether quantity of life or quality of life should be accorded priority.

Factors to be considered in making these decisions include the following:

1. The probability that a particular form of medical treatment will help sustain the life of the patient.
2. The length of time that the life of the patient is likely to be sustained.
3. The anticipated risks and side effects of the treatment
4. Other forms of treatment available, if any, and their relative advantages and disadvantages
5. The patient's adjustment to hospitalization or to the treatment
6. The extent to which the treatment will interfere with the person's most cherished activities.
7. Available support systems at home or in alternative institutional settings

Second opinions and consultations are often useful in clarifying and assessing these factors.

C. Chronically Ill Individuals

The foregoing should not be taken to imply that chronically ill persons should be allowed to die because their lives are judged to be not worth living or because they

are viewed as burdensome or useless to society. Whether the person in question is a newborn infant with serious birth defects or an aged person whose capacities have begun to wane, the Christian response in such cases must be a strong presumption in favor of treatment. Exceptions might arise in cases of extreme and overwhelming suffering from which death would be a merciful release, or in cases in which the patient has irretrievably lost consciousness.

Just as abandoning the chronically ill to die is inconsistent with Christian conscience, so also is abandoning the family members who, along with the patient, must bear the psychological, social, and economic costs of chronic illness. Responding to these needs involves the stewardship of time (e.g., offering to share in the responsibility of caring for a chronically ill person) as well as seeking to make adequate financial resources and supportive services available, whether by public or private means.

Finally, to assert that all lives are worth saving does not eliminate the necessity of establishing priorities when available medical resources are inadequate to treat all who are in need. In these tragic situations, it is inevitable that the priorities that are established, regardless of what they might be, will result in reduced levels of treatment for some, perhaps even to the point that death occurs earlier than would be the case if adequate resources were available.

REFUSING TREATMENT

If the patient has the prime decision-making role, the question then becomes one of refusing treatment for oneself, rather than withdrawing or withholding treatment from another. Since our responsibilities for stewardship of our own lives do not differ significantly from our responsibilities for the lives of others, the general guidelines outlined above are pertinent here also. Thus, for example, one may in good conscience refuse burdensome treatments in some situations.

A further question, however, also arises: Should persons be allowed to refuse treatment in situations in which such refusal is not supported by these guidelines? Or should they be treated in violation of their wishes? Here the principle of respect for individual self-determination comes into play. To treat a patient in violation of his or her deeply held, carefully considered, and clearly expressed preferences is to do violence to that person just as surely as would physically assaulting that person or deliberately destroying his or her property. This is as true in the case of an incompetent patient who has made his or her preferences known while still competent as it is in the case of a competent patient who can actively participate in the decision-making process.

At the same time, it must be emphasized that pain and other factors often distort the decision-making process, resulting in expressions of preference that may not represent a person's true wishes. In such cases, it may be appropriate to administer treatment (by authority of court order, if necessary) if so doing would sustain the life of the patient.

In all cases – including those situations in which a person's considered judgments are unmistakably clear – there is a continuing responsibility to care for and to extend the warmth of human community to that individual. A decision to allow refusal of medical treatment must never become an excuse for abandoning that person.

USE OF PAIN-KILLING DRUGS

In certain instances, some drugs administered in order to control pain experienced by terminally ill patients also have the effect of hastening the dying process, thus securing a better quality of life at the expense of quantity of life. As with burdensome forms of therapy, it is appropriate to ask whether there are alternative courses of action that do not pose this conflict – i.e., whether there are available means of controlling pain that would not hasten death. If there are not, the choice between quality and quantity of life cannot be avoided. In cases of great suffering, administering pain-killing drugs is justifiable even if this hastens the dying process. At the same time, adjustments in administering such drugs should be made so as not to deprive the patient of consciousness prematurely. In all cases, recognition should be given to patient preferences, when they are known.

ACTIVE EUTHANASIA

Deliberately administering a lethal drug in order to kill the patient, or otherwise taking steps to cause death, is quite a different matter. This is frequently called "active euthanasia" or "mercy killing" (as contrasted with the cases discussed above, which involve withholding or

withdrawing medical treatment, thereby allowing death to occur from a disease or injury).

Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering. To depart from this view by performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience.

Whatever the circumstances, it must be remembered that the Christian commitment to caring community mandates reaching out to those in distress and sharing hope and meaning in life which might elicit a renewed commitment to living.

CARING FOR THE LIVING AND FOR THE DYING

Health care includes not only attempting to cure disease and repair injury, but also caring for and relating to the patient as a person. As noted above, in the case of a terminally ill person for whom no cure is available, the responsibility to care not only continues, but assumes even greater importance, so that life may be lived to the fullest until death occurs.

Moreover, the responsibility to care includes extending care to the family and to all those who are involved in such situations. Hospice programs (which provide a wide

range of supportive services for patients and their families) and other supportive care programs represent useful and constructive ways of assisting the patient and family members in relating to the human dimensions of death and dying and subsequent bereavement. Such support for family members is needed in cases of sudden death, as well as prolonged terminal illness.

Health care professionals as well as family members have a responsibility to be truthful in relations with patients. Information must be shared so that the person can understand the disease and the options for treatment. Being informed of terminal illness is also essential so that one can prepare for death.

In death-and-dying situations, the Church's ministry of Word and Sacrament through its members and ordained ministers is of great significance. Remembrance of Baptism renews the Christian's sense of unity with Christ and the Church, and the Sacrament of Holy Communion serves as a reassurance of Christ's living presence and offers hope for the life to come. Simply to be with those for whom death is approaching – to pray with and for them, to listen and to respond, to comfort and to console – is also an essential ministry.

A commitment to caring community must also give recognition to the humanity of health care professionals, who are frequently asked to bear tremendous burdens. They, too, have a need for grief therapy sessions and other supportive programs, which in turn will enable them to minister more effectively and compassionately to patients and their families and friends.

A particular responsibility of each individual is making treatment preferences known, after careful consideration, so as to facilitate the decision-making process and relieve the burden on others. Living wills (signed and witnessed statements completed while a person is still in sound mind indicating treatment preferences) represent one way of doing this. Other areas of broader responsibility for patients and family members include considering the possibility of organ donation as a means of sharing life with others, authorizing an autopsy, and the donation of the body for scientific purposes.

FORGIVENESS AND THANKSGIVING

There is much that we do not know. We do not know when a debilitating disease may strike, what course that disease might take, and when death will occur. And there is much that we do not understand. Sometimes the death of a child or the large measure of suffering that may accompany the dying process seems to make no sense at all. Our finitude not only involves the fact that our life spans are limited; it is also reflected in the limitations of what we know and can understand.

Moreover, in responding to the dilemmas that are thrust upon us in death-and-dying situations, we sometimes make the wrong decision, or at least are uncertain as to whether we have made the right one. And we are often woefully inadequate in extending compassion and understanding to our fellow human beings. Even in the best of circumstances, our sins and shortcomings are manifold.

But this we know: God is merciful and forgiving. Thus, by grace, we can both experience forgiveness and forgive others, as God forgives us.

We also know that God may be closest to us in times of adversity, for then the pretensions that alienate us and the diversions which preoccupy us are stripped away. It is then that we learn to rejoice again in the marvelous gift of life, and the privilege of sharing this life with family and friends and all those we have known and loved. Thus even at the moment of death we can proclaim with the psalmist:

> O give thanks to the Lord, for he is good; for his steadfast love endures for ever! (Psalm 107:1)

IMPLEMENTING RESOLUTION

The Lutheran Church in America recommends to its congregations and their members, synods, agencies, and institutions, the following as appropriate ways of implementing the principles set forth in the statement "Death and Dying."

I. Congregations

A. Provide an educational program that includes sessions on death and dying, so as to encourage members to reflect about these issues within a Christian context.

B. Sponsor training sessions to help members learn how to minister to the chronically ill and to those in death-and-dying situations, and to members of their families.

C. Encourage the development of mutual support groups within the congregation.

D. Join with other congregations and community groups to establish and maintain supportive care programs, including hospice care.

II. Churchwide Agencies, Synods

A. Prepare study material on death and dying to be used in educational programs.

B. Provide continuing educational opportunities and supportive services for clergy and laity to help them relate effectively to death and dying.

C. Encourage the development of hospice programs and other supportive care programs designed to respond to the human dimensions of death and dying.

D. Advocate with federal, provincial/state and local governments legislation and administrative regulations that advance the best interests of persons with respect to dying and death.

E. Advocate and support public and private measures designed to relieve the economic burden of terminal illness and to promote the just distribution of medical resources.

III. Church-Related Health Care Institutions and Social Service Agencies

A. Review and discuss institutional policies in terms of the guidelines outlined in the social statement.

B. Introduce and maintain programs designed to help health care professionals deal with death and dying.

C. Introduce and maintain programs designed to help patients and members of their families relate to death and dying.

IV. Educational Institutions (Seminaries and Church-Related Colleges)

A. Design college courses and programs on issues related to death and dying.

B. Provide seminary courses and programs to train future pastors and lay professionals for their ministry to the dying and to members of their families.

C. Cooperate with the synods in ŏffering continuing education for clergy and laity in this area of concern.

V. Individuals

A. Prayerfully examine the ethical questions related to death and dying and make treatment preferences known to family members and to others as appropriate (e.g., by completing a living will).

B. Share time and other resources with those whose lives are affected by chronic illness or by death and dying.

C. Consider the possibility of organ donation as a means of sharing life with others.

ADDENDUM TO SOCIAL STATEMENT ON DEATH AND DYING

Adopted by the Eleventh Bienneal Convention
of the Lutheran Church in America
Louisville, Kentucky
September 3-10, 1982

The Twelfth Biennial Convention of the Lutheran Church in America (Toronto 1984) adopted a memorial from the Virginia Synod directing "that all references in the Death and Dying Statement that call death '(a) friend' be changed to 'merciful'."